Help with hospitalization and other billing questions

"Aunt Alice asked for my help. She is in the hospital, and I'm trying to figure out her bills."

START HERE

Medicare covers inpatient hospital care when all of the following are true:

- A doctor says the person with Medicare needs inpatient hospital care to treat an injury or illness
- The person with Medicare needs the kind of care that can be given only in a hospital
- The hospital has an agreement with Medicare
- The Utilization Review Committee of the hospital approves the stay while the person with Medicare is in the hospital
- A Quality Improvement Organization approves the stay after the bill is submitted

Medicare helps pay for the following services:

- Care—general nursing
- Room—semiprivate room
- Hospital services—meals, most services and supplies

Medicare doesn't pay for the following services:

- Care—private-duty nursing
- Room—private room (unless medically necessary)
- Hospital services—television and telephone

BASIC INFORMATION

Knowing about deductibles, coinsurance, and co-payments can help you understand Medicare billing.

The **deductible** is the amount that a person must pay for health care or prescriptions, before the **Original Medicare Plan**, the person's prescription drug plan, or other insurance begins to pay. For example, in the Original Medicare Plan, the person with Medicare pays a new deductible for each **benefit period** for Part A and each year for Part B. These amounts can change every year.

Coinsurance is the amount the person you care for may be required to pay for services after he or she pays any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the **Medicare-approved amount**. The person you care for will have to pay this amount after he or she pays the deductible for Part A and/or Part B. In a **Medicare Prescription Drug Plan**, the coinsurance will vary depending on how much the person you care for has spent.

In some Medicare health and prescription drug plans, a **copayment** is the amount the person you care for will pay for each medical service, like a doctor's visit or prescription. A copayment is usually a set amount. For example, this could be $10 or $20 for a doctor's visit or prescription. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

IMPORTANT: When a person with Medicare is covered by more than one health insurance plan, there are rules about whether Medicare or the other insurer pays health care bills first. This is called "coordination of benefits." Sometimes, the other health insurance pays the person's health care bills first, and the person's Original Medicare Plan or Medicare Advantage (MA) Plan pays second. Other insurance that may pay first includes an employer's or union's group health plan coverage, no-fault insurance, liability insurance, black lung benefits, or workers' compensation. If the person you care for has other insurance, it is important that you tell his or her doctor, hospital, and pharmacy so that his or her bills get paid correctly.

If you have questions about who pays first, see the "Find Out More" section on this page.

FIND OUT MORE

Who pays first? Call Medicare's Coordination of Benefits Contractor at 1-800-999-1118 if you have other insurance and you have questions about who pays first. TTY users should call 1-800-318-8782.

www.medicare.gov
Get free copies of the booklet "Medicare and Other Health Benefits: Your Guide to Who Pays First", or get an "Appointment of Representative" form. You can also request these publications or an "Appointment of Representative" form by calling 1-800-MEDICARE (1-800-633-4227).

www.healthfinder.gov
Information from many federal agencies, states, professional associations, nonprofit organizations, and universities.

www.ncoa.org
Identify programs to improve older adults' quality of life from the National Council on the Aging.

www.seniors.gov
The federal website for seniors with a locator to find services near where you live or work.

STATEMENT AND BILLS

If the person you care for is in the **Original Medicare Plan**, he or she will get a Medicare Summary Notice (MSN) in the mail every three months if he or she had a Medicare-covered service during that period. The notice lists the services the person you care for received and the amount he or she may be billed by a hospital, doctor, or other provider. These notices are sent by companies that handle bills for Medicare. If you disagree with the information on the MSN, you can file an appeal. Information on how to appeal is included on the notice. For more information about the MSN, including a sample MSN and information on how to read it, visit www.medicare.gov on the web and select "Medicare Billing." Or, call 1-800-MEDICARE (1-800-633-4227) and say "Billing."

IMPORTANT: Notices and bills for **Medicare Advantage Plans** and **Medigap policies** will look different than the MSN for people in the Original Medicare Plan. If you have a question about a Medicare Advantage Plan or Medigap policy, you will need to call the benefits coordinator at the company or health plan that offers the plan. To locate telephone numbers, you can look at the notice or bill from the plan. Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

The person you care for has certain guaranteed rights. One of these is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services. No matter how this person gets his or her Medicare health care, there is generally a right to appeal. Some of the reasons for an appeal are when

- the person you care for doesn't agree with the amount that Medicare paid.
- a service or item isn't covered and the person you care for thinks it should be covered.
- a service or item is denied, and the person you care for thinks it should be paid.

Information on how to file an appeal is on the MSN, in the health plan materials, or in the drug plan materials. If the person you care for decides to file an appeal, ask the doctor or provider for any information that may help the case. You can also call the State Health Insurance Assistance Program (SHIP) for help filing an appeal (see page 23 for their telephone number).

If the person you care for wants someone to file an appeal on his or her behalf, he or she will need to complete an "Appointment of Representative" form. To get a copy of this form, see the "Find Out More" section on page 12.

For more information about your appeal rights, visit www.medicare.gov on the web to get a free copy of "Your Medicare Rights and Protections." Under "Search Tools," select "Find a Medicare Publication." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a free copy can be mailed to you. TTY users should call 1-877-486-2048.

IMPORTANT: The Medicare Beneficiary Ombudsman works to ensure that people with Medicare get the information and help they need to understand their Medicare options and to apply their rights and protections. The Medicare Ombudsman works to ensure that existing Medicare information, counseling, and assistance resources work the way they should to help people with Medicare with complaints, appeals, grievances, or questions about Medicare. Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) for more information, to ask questions, and to submit complaints about Medicare to the Office of the Medicare Ombudsman. TTY users should call 1-877-486-2048.

Snapshot of Original Medicare Coverage for Inpatient Hospital Stays (Medicare Part A)		Medicare Helps Pay	Medicare Doesn't Pay
Care	General Nursing	●	
	Private Duty Nursing		○
Room	Semiprivate Room	●	
	Private Room (unless medically necessary)		○
Hospital Services	Meals	●	
	Television		○
	Telephone		○
	Most Services and Supplies	●	

Certain conditions will apply.